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MEDICAL SERVICES

# **INTERPERSONAL RELATIONS IN THE CARE AND MANAGEMENT OF PATIENTS**

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# ***SUMMARY of CHANGE***

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INTERPERSONAL RELATIONS IN THE CARE AND MANAGEMENT OF PATIENTS

Not applicable.

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## MEDICAL SERVICES

# INTERPERSONAL RELATIONS IN THE CARE AND MANAGEMENT OF PATIENTS

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**History.** This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

**Summary.** Annually, and as often as deemed necessary, commanders of medical treatment facilities will supervise the instruction of assigned personnel in the role of interpersonal relationships in the care and management of patients. The instructional material in this pamphlet is provided as an aid for local innovation. Diagnosing and correcting human relations problems must be a continual process if concerned patient care is to become a reality. Many of these problems can be

addressed in an effective staff development program, if it is run in a way which allows people to discuss their feelings and share their ideas for constructive change. Chapter 2 presents a nontechnical discussion of several basic factors that influence human behavior in social situations. Chapter 3 focuses on patient behavior as a response to the unfamiliar stresses of illness, as well as to the influences discussed in chapter 2. Chapter 4, built upon the foundations of the preceding chapters, discusses several guidelines for establishing and maintaining good interpersonal relations among medical staff members and with the patient. Chapter 5 provides methods for determining the human relations climate in the medical treatment facility and suggestions for improvement.

**Applicability.** This pamphlet applies to the Active Army, the Army National Guard (ARNG), and the US Army Reserve (USAR). It applies to all Army Medical Department (AMEDD) personnel assigned to Army medical treatment facilities (MTFs) and units.

**Proponent and exception authority.** The proponent of this pamphlet is the Office of The Surgeon General.

**Impact on New Manning System.**

This pamphlet does not contain information that affects the New Manning System.

**Interim changes.** Interim changes to this pamphlet are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

**Suggested Improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Commandant; Academy of Health Sciences, US Army; ATTN: HSHA-TLD; Fort Sam Houston, TX 78234.

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\*This pamphlet supersedes TC 8-4, 31 May 1976.

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## **Chapter 1**

### **INTRODUCTION**

#### **1-1. Purpose**

*a.* This pamphlet is to be used as a guide for personnel of the Army Medical Department who have been assigned to Army medical treatment facilities and units to perform specific duties and assume designated responsibilities in the care and management of the sick and injured. Its purpose is threefold, to—

- (1) Provide these personnel with a practical knowledge of patient behavior.
- (2) Develop an understanding of the patient as a sick person with a certain point of view.
- (3) Aid in developing patient relations that will contribute to the therapeutic goal of the health care team.

*b.* This publication may also be used as a guide for commanders of medical treatment facilities and units in their programs of instruction in the care and management of patients.

#### **1-2. References**

Related publications are listed in appendix A.

#### **1-3. Explanation of abbreviations**

- a.* AMEDD—Army Medical Department
- b.* ARNG—Army National Guard
- c.* MTF—medical treatment facility
- d.* USAR—US Army Reserve

## **Chapter 2**

### **UNDERSTANDING HUMAN BEHAVIOR**

#### **2-1. General**

The basic purpose of modern military health care is to treat the sick person as early as possible. The sophisticated technology of medical instruments and machines is rapidly increasing our ability to accomplish this goal. It is also becoming increasingly evident that the attitudes of the patient have a direct effect upon promoting or obstructing the goal of an early cure. These attitudes may be influenced by the patient's relationships with the many people who come in contact with him or her during treatment. These contacts, or interactions, between individuals and other individuals or groups are known as interpersonal relations.

#### **2-2. Importance of good interpersonal relations**

Effective interpersonal relations are recognized as an aid to efficient organization in any institution. Indeed, the success of an institution depends as much upon how its members interact as it does upon the machinery with which they work. In the military organization, effective interpersonal relations are an aid to accomplishing the mission with the greatest conservation of time and manpower. Cooperative interpersonal relations will help to unite medical personnel into teams whose members mutually support each other to accomplish their goal. They will provide an agreeable atmosphere for the practice of medical and technical skills. Since the patient's attitude and behavior are influenced by the attitudes of those around him or her, positive interpersonal relations among members of the health care team are also important to the goals of an early cure.

#### **2-3. An approach to understanding human behavior**

In order to understand how people interact with each other, we must seek to understand what factors influence the way persons behave. Human behavior is very complicated, but there are practical guides that will assist you in approaching an understanding of yourself and other individuals. *First*, remember that there is usually a reason for human behavior; there is usually a desire to achieve some goal. *Second*, people are individuals. In practice however, this fact is often ignored. People may resemble each other in many ways, but each person is unique in several characteristics that are important to him or her. Your sensitivity to individual differences is the basis for one of the most important guides to interpersonal relations: treating people as individuals. A *third guide* in dealing with people is to approach each individual with an open mind by seeing beyond his or her present or past behavior and accepting him or her as a worthwhile individual who has the capacity to change and develop if he or she so desires.

#### **2-4. Basic factors influencing human behavior**

The quality of interpersonal relations depends upon how the individuals involved respond to a situation and to each other. There is a wide variety of factors that may influence how an individual responds. Your ability to recognize the degree of influence of these factors in each person will help you to develop more effective interpersonal relations.

Behavior is influenced in varying degrees by several factors including: Needs, social and cultural standards, and by the nature of the person's views of him- or herself.

## **2-5. Basic needs of man and woman**

*a. Survival needs.* There are certain primary needs that are obviously important to all of us. When these needs are not satisfied, they are usually the center of our attention. Among the survival needs are hunger, thirst, rest, exercise, freedom from pain, and elimination of body wastes. We will see later that the satisfaction of this group of needs is prescribed by the culture of the individual (para 2-7b).

*b. Security needs.* Each individual needs a certain degree of a feeling of security in his or her everyday living. In each of us there is some fear of the unknown. We feel a little more comfortable and secure when our environment appears to be orderly, stable, and predictable. Sometimes the need for security is so great in an individual that he or she has an antagonistic attitude toward change or new experiences.

*c. Belonging needs.* Man and woman are known as social animals because their tendency to be individualistic is offset by belonging needs which include the desire for approval by others. These needs cause them to want to be accepted members of a group (para 2-7a).

*d. Esteem needs.* Man and woman not only want to be accepted members of a group; they also desire that others respect and appreciate them. In their own mind, they build an ideal picture of themselves (para 2-6) which they want to have recognized and appreciated. Unless they attain this goal, they may lose their self-respect.

*e. Self-development needs.* To varying degrees, man and woman also have a desire to be less dependent on the outer world of people and things for the satisfaction of their needs. They have a desire to grow and develop toward becoming fully themselves without depending upon others. In other words, they set their goals and measure their accomplishments according to the image that they have of themselves, of what they are, and of what they feel they must be in order to maintain their self-respect.

## **2-6. The self-concept**

Man and woman differ from other forms of life in their ability to recognize the existence and importance of the self-concept in others. By seeking to understand the self-concept of another person they can take an important step toward good interpersonal relations. The self-concept is a kind of personal definition, a setting up of expectations of how you will behave, what you will learn, what people should think of you, and what kinds of things you will find satisfying. It is a picture of yourself that you strive to enhance and maintain. All of your behavior is designed to preserve this self-picture, to strengthen it, and to protect it from any person or thing that threatens it. Your attitude toward any person or event will be influenced by this self-concept. Persons are pleased by experiences that maintain or enhance the self-concept, and disturbed and antagonistic to those which threaten it. It must be recognized and respected when interacting with others on the health care team with the patient.

## **2-7. Factors that influence the self-concept**

What you are and what you may become are influenced by everything touching your daily life. The concept that you form of yourself is influenced by the type of individual you are, both physically and mentally, by society, by culture, by your physical environment, and by the activities that you engage in to achieve your goals. The directing and limiting influence of these factors is widespread and subtle. The self-concept does not form and then operate once and for all. Each recurring problem challenges it, demands defense of it, and offers possibilities for development and change.

*a. Influence of the social group on the individual.* The human's desire to associate with fellow humans is one of the strongest human characteristics. Craving for social respect and approval of persons who are important to the individual is so strong that he or she will frequently modify his or her behavior and sometimes even self-concept in order to be in harmony with those who are important to him or her. These important persons often constitute members within a group who confirm and support one another. The fellow-feeling of group membership is an important influence on self-concept and behavior. In varying degrees, everyone wants approval by his or her group, respect for what he or she is, and recognition for what he or she can become. In a closely knit group the individual learns to subordinate his or her own selfish goals to those of the group. He or she accepts and adopts the ideals of the group and makes them his or her own. Consequently, though maintaining certain aspects of individuality, he or she becomes in a way a symbol of his or her group. By understanding the attitudes, standards, and aims of an individual's group, you can gain insight into his or her behavior in interpersonal relations.

*b. Influence of culture on behavior.* Emerging from the culture of our society are the norms, customs, values, beliefs, and laws which shape our ideals of what behavior ought to be for certain situations. Our culture influences how we think about the world and how we perceive it. It also prescribes what feelings can be expressed, by whom, and how. The culture is a traditional design for living based on approved patterns of behavior. It prescribes the acceptable ways to satisfy and express the basic needs discussed earlier (para 2-5). Its subtle influence is passed on from one generation to another primarily during childhood when the person learns how to get along in his family and in important groups. In our society, there are many acceptable behavior patterns because of the wide variety of occupational groups, economic classes, and ethnic and racial sectors that make up the national society. Your ability to

recognize and respect the importance of different values, beliefs, and customs in our society will enable you to develop more effective interpersonal relations.

## **2-8. Frustration and conflict**

Over a period of time each individual appears to direct his or her efforts toward satisfying basic needs, toward developing and expressing self-concept, and toward maintaining customs, values, and beliefs. He or she is motivated, that is, he or she feels a desire to satisfy these needs in life by moving toward accomplishing life goals. As long as these motives for behavior are satisfied, or satisfactory progress is being made toward fulfilling them, there is little difficulty. Human behavior, and consequently interpersonal relations, however, may vary significantly when satisfaction of these motives for behavior is blocked or when the person is faced with having to satisfy two or more incompatible motives. Many life situations involve both conflict and frustration. Furthermore, the interaction of individuals is often a source of conflict and frustration.

*a. Conflict.* Throughout each day we are constantly choosing between two or more alternative motives. Often the choice is automatic when it is relatively unimportant. A person experiences inner conflict, however, when it is difficult to choose between two goals, or to choose which of two or more needs to satisfy when only one can be satisfied at a given time. Social conflict between people with differing goals, interests, values, and intentions is also an everyday occurrence. Social conflict may involve competition for status, prestige, recognition or freer expression of the self-concept. Conflict in itself is not *bad*; it is only when the behavioral responses to conflict are hostile, destructive, weakening, or futile that conflict is a negative influence. It is not the purpose of interpersonal relations to avoid all conflict, or to create an ideal, peaceful, but inactive state. It is necessary to learn how to work out conflicts objectively in a socially approved manner (para 2-10a).

*b. Frustration.* An individual experiences frustration when the path to his or her goals is blocked, when the means to satisfying a need are obstructed, or when the expression of interests and values is thwarted. If a person cannot find a way around the block, or if he or she cannot substitute another goal or modify values, a state of frustration is likely to result. The degree of frustration is related to the intensity of the desire to reach the goal, and to the extent to which the goal is blocked. If a person is prevented from attaining a goal in one fashion, he or she may try a different method. Or it may have the effect of making the person try harder than ever to reach the blocked goal. In this case, behavior may become aggressive as sometimes happens when one person frustrates another. Frustration may result in more childish behavior, or cause the individual to be peevish and unreasonable. For example, a patient may feel frustrated because illness is slowing down his or her chances for promotion. The frustration over the blocked goal may cause him or her to complain unduly about the hospital service, the medical treatment, or the inattention of family. Some persons can undergo frustration without being hurt by it; what is frustrating to one may not be to another, or it may be frustrating to differing degrees. The effects of frustration depend upon the nature of the unsatisfied need, the degree to which the goal is blocked, and upon the personality of the individual.

## **2-9. Some emotional by-products of frustration and conflict**

If motivation is very intense, frustration and conflict may produce anxiety and stress. The symptoms are physical as well as mental: The adrenal glands pour out adrenalin; digestion slows down; the heartbeat speeds up; more blood pours into the peripheral muscles; and general tension results. Mild anxiety in patients is often characterized by restlessness, sleeplessness, hostility, belittling, misunderstandings, and the like. It is also manifested sometimes in persistent questioning, constant seeking of attention, reassurance, or approval. If personal prestige, feelings of worth, dignity, and self-respect are threatened, anxiety usually increases, many times reaching the stage of a phobia (an acquired need to avoid certain situations), and obsession (ideas that dominate and hence limit one's experiences), or a state of acute anxiety. Uncontrolled or undirected anxiety is harmful, but when held within limits it can be an aid to interpersonal relations by sharpening alertness and perception. Anger or rage may be another by-product of frustration or conflict. These emotions are usually demonstrated by aggressive behavior, and if uncontrolled impede the solution of the problem. Depression and fear are two other emotions sometimes evoked by frustration or conflict. If carefully directed, these emotions may produce beneficial results, but if allowed to go uncontrolled over a long period of time they will aggravate the undesirable situation and may produce physical disorders such as allergies, ulcers, or digestive disorders. Your sensitivity to these emotions will enable you to deal with problems of the patient before they develop into obstructions that prolong his illness.

## **2-10. Satisfactory adjustment to problems of frustration and conflict**

*a. Solving problems by cultural and logical methods.* Man and woman have a tendency to solve problems of frustration and conflict by relying on habits and/or emotions. The society's cultural patterns provide us with ready solutions for dealing with many life problems, and thus spare us from having to make decisions on many routine, uncomplicated problems of daily living. In our society, however, the difficult, involved problems are more effectively approached in a logical manner. Solving a problem logically follows a process of locating and defining the problem as exactly as possible, gathering all related facts, suggesting and testing possible solutions, choosing the best solution, and then taking action in the light of your findings. The effectiveness of your relations with patients can often be

significantly enhanced by approaching, and helping them to approach, their more complicated problems as logically as possible.

*b. Alternative approaches to problem solving.* If, after the process of logical reasoning, you are still unable to solve a problem, frustration can sometime be reduced by identification, by discussion, by hobbies and recreation, or by a sense of humor. Through identification with others, a person can achieve a sense of personal satisfaction through their successes, or can solve his or her problem as he or she feels the group members might solve it. Frequently when a person discusses his or her own problem with a good friend or an understanding person in whom he or she trusts and tells it in his or her own words, he or she begins to understand it better and more realistically appraise its gravity. By taking a person's mind from troubles through recreation or hobbies, he or she is often able to approach the problems later with a new perspective. The result may be a minimizing of the anxiety or a redirection of efforts to solve the problem. Many times an underlying sense of humor will help reduce tensions of frustration, result in a clearer understanding of the other person's point of view, or will reduce a patient's problem in comparison with greater problems others are facing. An effective relationship with patients may be promoted by encouraging them to talk about the groups that are important to them, to discuss their problems as they see them, and to participate in available activities that interest them.

## **2-11. Ineffective and undesirable reactions to conflict and frustration**

### *a. General.*

(1) In many instances, the reactions of a person suffering from conflict or frustration will not take the purposeful, directed channels above. People under stress often do not act in the ways that they ordinarily do. We may observe a strong tendency to make decisions based upon an inadequate consideration of the problem by—

- (a) Refusing to see the whole problem.
- (b) Exaggerating a small part of the problem.
- (c) Omitting or distorting facts.
- (d) Failing to gather sufficient facts.
- (e) Making overhasty solutions.
- (f) Exaggerating small problems.

(2) Inefficient attempts to adjust to conflict and frustration may also be manifested through various forms of resignation, detour behavior, substitution of goals, avoidance of situations, or aggression. Sometimes such reactions may be temporarily effective, but more often they tend to aggravate the undesirable situation.

*b. Resignation.* In a sense, resignation is a passive state of mind which discourages action toward solution-making. It may be a desirable reaction when facing situations that are impossible to change. Resignation may also result in accepting—without any efforts toward changing—an undesirable situation that could be remedied if the attempt were made. Interpersonal relations may also be influenced when an outward appearance of resignation is actually hiding underlying feelings of hostility and aggression. This type of reaction is actually less desirable than outward aggression because the inner tension, anger, and emotional stress tend to increase until they emerge suddenly and uncontrollably to the surface, sometimes causing acts of violence and severe anxiety. The brooding type of reaction to frustration is especially detrimental because it frequently is not even recognized by the person suffering it.

*c. Detour behavior.* In order to achieve a goal, a frustrated person may detour the obstacle by finding another means of satisfaction besides the one that is blocked to him or her. This response is effective if it is based on a realistic appraisal of the obstacle. Detour behavior may be an undesirable response to frustration when a person becomes too dependent upon it and resorts to detouring obstacles instead of attempting to confront and logically resolve problem situations.

*d. Substitution of goals.* Instead of detouring the obstacle to a goal, a frustrated person may decide to change the goal. The effectiveness and desirability of this behavior depend upon how important the neglected goal is to the person's life, and how well the new goal actually substitutes the neglected goal. As in the case with detour behavior, changing or substituting goals may be an undesirable response if it tends to encourage vacillation or weakness in pursuing future goals.

*e. Avoidance of situations.* A person may adjust to a frustrating situation by avoiding or leaving the field. Avoiding a situation physically or mentally when it becomes unbearably frustrating may be a healthy adjustment. It is ineffective, however, when the source of frustration is within the individual, rather than the exterior factors of the situation itself. If the source of frustration is internal, avoiding the situation merely postpones frustration until a similar situation is later encountered. Ineffective avoidance of frustrating situations can lead to extreme regression and may result in alcoholism or drug addiction.

*f. Aggression.* The most frequent response to frustration is varying degrees of aggression. Individuals tend to be aggressive toward the person or thing that blocks their way toward satisfying a goal. The stronger the desire to reach the goal, the greater is the tendency to become aggressive when thwarted. Sometimes aggression is misplaced: that is, it is directed toward innocent people or things. In this case the particular object or person selected for aggressive action

is likely to be one that will offer the least resistance or retaliation. It may, in some instances, be directed toward the self and result in self-inflicted injury or in debasement of the self.

## **Chapter 3**

### **THE BEHAVIOR OF PATIENTS**

#### **3-1. General**

Up to this point, attention has been centered on the multitude of factors that influence the behavior of people when they interact with each other. The factors may be disrupted and aggravated when a person becomes a patient. The implementation of constructive interpersonal relations must take into account the pressures and strains felt by a person due to his or her illness or injury, as well as the factors influencing the behavior of a person before he or she becomes a patient.

#### **3-2. The stress of illness**

Most normal people have some difficulty in adjusting to the changes and feelings of fear, pain, and helplessness experienced as a patient. A person who is ill suffers whether the illness is mild or severe. He or she is experiencing feelings that are not normal to him or her, feelings to which he or she has not learned how to adjust. Patients are people under stress; hence, there is no physical illness without some emotional involvement. Illness not only interrupts the ordinary patterns of living but the status quo is altered without the patient's volition or choice. The orderly life path previously envisioned is no longer predictable. A patient's concern about self is intensified; he or she must wonder if he or she will continue to be accepted and valued by the meaningful persons in his or her life. Moreover, he or she is often in pain and anxious about many facets of his or her situation. In order to develop positive interpersonal relations with a person who is sick, you must consider what—

- a. Kind of person he or she was before the illness.
- b. Kind of illness is affecting him or her.
- c. Significance he or she attaches to the illness in regard to his or her comfort and way of life.

#### **3-3. Personal factors predetermining the response to illness**

a. Each person reacts differently to the stresses of illness and hospitalization and therefore must be approached individually—not as a case. The attitudes toward illness and the ways to behave with respect to dependency and handling of pain vary among different cultures. If a patient has been reared in a family that stresses stoical acceptance of suffering concerning expression of discomfort, it is sometimes difficult to determine the degree of pain he or she is suffering or the extent of the disease. Another patient, however, may have experienced attitudes in a cultural environment in which it was considered acceptable to complain loudly. His or her behavior will place different strains on handling interpersonal relations.

b. The habitual patterns of response to stress which a person has developed up to the time of assuming the role of a patient will influence the manner in which he or she accepts and copes with the new stress of illness. A patient may strive to take a logical approach (para 2-10), or you may find that in order to establish good interpersonal relations it will be necessary to be sensitive to manifestations of resignation, detour behavior, goal substitution, avoidance of situations, or aggression (para 2-11).

#### **3-4. Common feelings of sick people**

a. *Dependency.* Keeping in mind that each person is an individual, consider in a general way the feelings and attitudes which most sick people have and how their customary way of doing things has been interrupted. The patient is no longer self-sufficient; he or she has been forced to seek the help of others which may contradict the cultural ideal of independent action. He or she is unable to make the uncomfortable symptoms disappear, and he or she has involuntarily given up much personal control of the simplest everyday functions. Despite his or her will, he or she must depend upon others, often strangers, for vital treatment even though throughout life he or she may have associated independence, self-competence, and mastery with valued maturity and self-respect. This dependence on others requires a certain posture of helplessness and passivity similar to childhood behavior in terms of personal responsibilities. Response to this state of dependency may be manifested as a diminishing self-respect and a fear that important people, including the hospital staff, may view him or her in a less favorable light or no longer accept him or her as an adult. Although, many patients may find it difficult to be dependent upon others, a state of childish helplessness can be gratifying when the patient discovers that in the role of a patient it is acceptable to be dependent. The resultant behavior may reflect that he or she enjoys the advantages of being cared for, relieved of responsibilities, and removed from dangerous situations without disapproval.

b. *Strangeness.* When a patient is admitted to a hospital he or she is isolated from his or her familiar world, from the accustomed security and predictability of friends, family, associates, work, and superiors. The large wards, the long halls, the sight of strange equipment, white-clad hospital personnel, strange smells—all of these are unfamiliar and

often bewildering. Even the small things which make him or her a particular individual, such as clothes and valuables, are taken away and he or she is assigned to a special type of bed on a ward full of strangers. Unless he or she has special orientation and reassurance, he or she will feel lost and alone. He or she is then subjected to tests and examinations which he or she may not understand and which may be painful. He or she is sometimes put on a stretcher and wheeled down long corridors to clinics where he or she has to wait before undergoing unfamiliar tests. Everyone seems to be too busy to offer him or her explanations. Thus, he or she hesitates to ask questions; besides, in some cases he or she is afraid to know the answers. At ward rounds he or she usually is excluded from the discussion of his or her case. If he or she overhears the mysterious diagnosis, it usually contains words which he or she does not understand. Many of these problems beset the patient who is making his or her initial visit to a clinic. Strangeness can be minimized by genuine reassurance and clear explanations.

*c. Fear.*

(1) *Sick people are often fearful.* They may be afraid of the illness itself or of the treatment or surgery they must undergo. They dread the pain, the uncomfortable feelings, the anesthesia, the possibility of long periods of inactivity or permanent damage. This dread and fear is often influenced by what the patient learned about illness from his or her cultural background. Sick people may also fear the effect of their illness on their family, on their job, or on a particularly cherished hobby. Some of the questions always on the mind of a rational patient are the following:

- (a) Will I survive?
- (b) How long do I have to suffer like this?
- (c) Will there be any complications?
- (d) Will I ever have to suffer like this again?
- (e) What will people think of this illness?

(2) *Society's attitudes.* In regard to (e) above, keep in mind that different kinds of illnesses are regarded differently by our society. These attitudes are influenced by the source of illness, its nature, the part of the body affected, and the kind of treatment to be applied.

*d. Irritability.* The discomfort and pain of illness with its accompanying emotional involvement usually cause the patient to become irritable. He or she may become upset over minor matters and place undue emphasis upon them. Or he or she may be restless and impatient, becoming provoked over the slightest interruptions or discomforts.

*e. Concern over body feelings.* A sick person becomes overly concerned about feelings and sensations which he or she would never notice if well. Even normal sensations now appear abnormal. He or she has had his or her attention focused on body sensations; in fact, everyone repeatedly asks how he or she feels and if he or she has pain.

*f. Suggestibility.* All the above factors (dependency, strangeness, fear, irritability, and concern over body feelings) contribute to another characteristic of patients—suggestibility. A patient hears about the complaints or symptoms of others and begins to wonder if he or she has them too. After a period of concentration on the symptoms, the patient may think he or she does have them, and may suffer just as keenly as though they were real. Even healthy persons are suggestible, but sick people are exaggeratedly so.

*g. Loss of interest in surroundings.* Sometimes a sick person concentrates on his or her own illness to such an extent that he or she forgets that anything else of any importance is happening. To him or her, the illness may be all-important, all-absorbing. He or she may forget his or her job, family, and goals in life for awhile until recovery begins. He or she sees only a small part of the hospital and may see that only in relation to self. He or she may feel no responsibility for the many other patients in the hospital or care about them. He or she often feels that he or she should be relieved of responsibility of any kind because he or she is sick. Gradually, as he or she begins to recuperate, his or her interest hopefully widens again and he or she regains a normal point of view.

### **3-5. Ways in which patients may react if their needs are not satisfied**

*a. General.* A majority of patients are able to endure delays and await attention to their needs without becoming demanding or without withdrawing entirely from the situation (para 2-10). These patients are those whose needs have been satisfied in the past and who are able to control and direct their attention toward recognizing the limitations of patient care. A significant minority of patients are not able to exercise control. The tension created by their unsatisfied needs may be manifested through undesirable behavior that will complicate relations with them, and their relations with other patients. This behavior is not necessarily evidence of mental disorder and should not be considered as such.

*b. Aggressive behavior.* Perhaps one of the most common and disruptive reactions of patients is aggressive behavior. This varies from sarcastic remarks to explosive and sometimes destructive behavior. The patient may feel hostile toward others or even toward him- or herself, perhaps impelling him or her to strike out against something or somebody. His or her aggressive feelings may be manifested directly and verbally by behavior such as *talking back*, resisting directions or treatment, or using various attention-getting devices, such as bragging or chronically complaining about waiting, the food, the nursing care, or anything else that happens to annoy him or her even slightly at the time. The patient may delight in finding fault with others, or give vent to feelings by criticizing and belittling others. He or she may appear to take delight in causing inconvenience and in annoying others intentionally. In some cases he or she may even use physical aggression by being carelessly rough with equipment or by fighting with other patients or the staff. Aggression may also be less direct, finding release from tension by spreading rumors or telling inappropriate

stories and jokes. It may also be manifested through noncooperation—holding back, doing only what is required, showing no initiative.

c. *Withdrawal.* If a patient's behavior is the withdrawal type, he or she becomes unsociable and unresponsive. He or she appears to lack interest in any activity; does not care to talk to the staff or to other patients; develops a loneliness which tends to make his or her situation worse; appears uneasy and cannot rest well; appears to lack interest, hope, or spirit; and may take no interest in his or her recovery. The withdrawn patient seems to have lost confidence in him- or herself and withdraws into a shell to avoid meeting or thinking about people or situations which he or she feels will be unpleasant and with which he or she feels unable to cope.

d. *Escape.* If his or her needs are not met, a patient may respond by escaping from the situation. Escape is like withdrawal in that he or she turns away from the situation. It is a step farther, however, because the patient directs personal thinking into an ideal situation in which he or she imagines that everything is as he or she would wish it to be. Everyone uses a certain amount of escape as a natural outlet for tension caused by unpleasant situations. A patient who persistently daydreams, however, may be worsening his or her situation by substituting imaginary accomplishments for action toward problem solving. Some patients come to depend on drugs or alcohol to blur reality and remove themselves temporarily from the tensions that they are experiencing.

e. *Regression.* The difference between escape and regression lies in the area into which the escape is made. A patient who is not critically ill or incapacitated but does not show signs of reacquiring his or her sense of independence and responsibility as he or she recuperates is said to have regressed. As an escape from his present worries, he or she has reverted back to childlike behavior with related immature attitudes. Change of any kind or new ways of doing things may be approached with fear and suspicion. Such a patient may appear overanxious and seek frequent reassurance and repeated explanations. He or she does not display the maturity to exercise a balance between basic needs and controlling forces. Apparently deriving little profit from experience, he or she demands immediate satisfaction of needs with little regard for those of others, and is unable to engage in long-range planning.

f. *Unsatisfied needs.* Needs cannot always be satisfied; sometimes they dwindle and are eventually abandoned and forgotten. Frequently, they are submerged or partially forgotten but continue to influence behavior. Mild adjustments to frustration are normal, routine, and universal. When the reaction becomes acute and greatly exaggerated, the patient is emotionally ill and needs immediate, constant, individual care consistent with his or her needs and human dignity.

### **3-6. Needs of the patient**

The *good patient* has been frequently described as one who obeys the hospital personnel without question, submits to what is asked of him or her and shows little initiative. If the mission of the health care team is to restore the patient to physical and mental health as soon as possible, this type of patient may not be the ideal type. Oversubmission may prove *not* to be an asset. His or her mind may be smoldering with frustration which increases because it is not released. Because of the emotional instability caused by illness, and if his or her needs are not satisfied, his or her adjustment is likely to be hindered if not unsatisfactory. Remember that a person who is ill is often less capable of logical problem-solving than when he or she is healthy. He or she must be regarded not only as a person coping with physical pains and handicaps but also as an individual who is sensitive to the responses and verdicts of his or her fellows and who struggles to maintain in their eyes the position he or she has established for him- or herself. His or her stress potential is high and his or her adaptive resources low. Patients require an extra amount of genuine sympathy, patience, and understanding. They must feel wanted in the hospital. Patients need to have confidence in the technical skill of the staff and feel that hospital personnel are interested in them as individuals. In order to facilitate satisfactory adjustment, start where the patient is. Little progress can be made unless the patient recognizes a need for adjustment. Approach with the expectation that a solution to the problem is possible. Open your own mind, make an active effort to put yourself in his or her place, resist the tendency to prejudge or categorize, try to gain his or her confidence, his or her cooperation, and his or her participation. Solution to the adjustment problem may involve change—in the patient's or your own point of view. Satisfactory adjustment, however, can be brought about through the skillful use of persuasion.

## **Chapter 4**

### **ESTABLISHING GOOD INTERPERSONAL RELATIONS WITH PATIENTS**

#### **4-1. Influence of other people on the patient's attitudes and behavior**

a. *Visitors.* The morale of a patient may be boosted when he or she feels that family and friends are concerned about him or her. Because of their concern for him or her, however, visitors may cause the patient to become overanxious about him- or herself. They may also retard his or her recovery when they make diagnosis of his or her illness, discuss their own problems to add to those of the patient, or stay too long and tire him or her out. Since the attitude of visitors toward the hospital is often conveyed to the patient, it is necessary that everyone who comes in contact with visitors create a favorable impression of the hospital. Courtesy, concern for the individual, sympathetic understanding, and helpfulness are factors which produce a lasting impression upon those who visit their friends and relatives. By mentally putting yourself in the place of the visitor, you can better understand how important consideration and kindness are.

*b. Other patients.* Immediately upon entering a ward, a patient looks to the patients already there for a key to his or her attitude toward the hospital. The attitude of the man or woman in the next bed who has been in the hospital for some time can have a constructive or negative effect on the new patient. The patient will begin to identify with the established group of oldtimers in order to gain some feelings of familiarity with the new surroundings. If the attitude of the group is positive and the general morale is high, the new patient usually adopts those attitudes and his or her behavior will reflect the positive atmosphere.

*c. Hospital personnel.* As has been pointed out in preceding paragraphs, a patient may be more emotional and more easily upset than a healthy person. Consequently, it is clear that people who come in contact with him or her while he or she is a patient have a significant influence upon his or her feelings and attitudes. As far as he or she is concerned, his or her problem is the most important. He or she should not be disparaged or belittled. The situation is sure to annoy him or her unless all hospital personnel make a special effort to orient him or her, to convince him or her that he or she is looked upon as an individual and to assure him or her that he or she is valued and is important to each one of them. Respecting the patient—his or her pride and belief in his or her own importance—is a necessary part of his or her treatment to which all hospital personnel contribute. Hospital personnel are human, and are subject to stresses and strains of life which interfere with their ability to think of the patient first and to react accordingly. If people recognize what is behind their own behavior, they are frequently able to *take out their frustrations* in other ways than *on the patient*. Some common human relations problems arise from the following factors:

- (1) Inattention to common courtesy.
- (2) Preoccupation with the technical aspects of medical care; e.g., diagnosis, lab work, etc., and inattention to the social and emotional needs of the patient.
- (3) Interprofessional staff conflicts and difficulties.
- (4) Job dissatisfaction.
- (5) Fatigue.
- (6) Preoccupation with personal concerns.
- (7) Treatment of patients as medical objects not as people.
- (8) Inability to interact effectively with people.
- (9) Poor communication skills.
- (10) Poor orientation to the purpose of their jobs as defined by the organization.
- (11) A tendency to regard the patient's problem as routine and insignificant. These are a few of the things that interfere with attention to the patient as a person. Some of them are *products of human nature however*, the staff can make sure that the patient does not lose out in the competition.

#### **4-2. The environment as a potential human relations problem**

Environmental factors in the facility can have a significant influence on how the patient views his or her care and how the staff views its work. No one likes to be kept waiting. When a person is ill or upset, or tending a sick child, waiting is even more difficult. In most clinics, waiting is unavoidable. To help the patient make the best of an undesirable situation, a comfortable waiting area is of the utmost importance. Studies of the relationship between human behavior and the physical environment show a definite relationship between an individual's state of mind and the relative pleasantness or unpleasantness of his or her surroundings. Some factors are easily correctable by a little thought and ingenuity, while others require a substantial expenditure of money and administrative time.

*a. Factors easily correctable:*

- (1) Unpleasant odors.
- (2) Dirty area.
- (3) Lack of waste receptacles.
- (4) Light bulbs out.
- (5) Dirty medical uniforms.
- (6) Poor arrangement of clinic waiting area.
- (7) Excessive noise and otherwise hectic atmosphere.
- (8) Lack of current literature to occupy patients.
- (9) No mirrors or lockers in patient dressing rooms.
- (10) Confusing signs and instructions.

*b. Factors correctable with a little more effort and money:*

- (1) Poor lighting resulting from too few fixtures.
- (2) Architectural barriers to patients who are not ambulatory.
- (3) Lack of adequate privacy during examination.
- (4) Lack of personal comfort items such as drinking fountains.
- (5) Lack of private areas where staff can talk with each other, or on the telephone, without being overheard by waiting patients.
- (6) Uncomfortable chairs.

- (7) Lack of television.
- (8) Waiting areas in the mainstream of clinic traffic.
- (9) Inadequate ventilation.

c. Many of the environmental problems in military facilities arise from lack of adequate space or old and outdated facilities. Too often, however, we blame the facilities for problems that could be solved if we used a little imagination and energy in improving the areas where we work.

#### **4-3. The health care delivery system as a potential human relations problem**

The large clinic system itself often contains factors which may hinder the effective delivery of health care. Bureaucratic systems are not inherently *BAD*, but they can become more concerned with their own convenience rather than with the delivery of service to patients. We need to be organized to give service. From time to time, we also need to look at the way we are organized and ask if we are getting the job done in the best way for the patient. Certain routine functions in health care require constant monitoring and occasional correction. We should determine who benefits from the present system: The patient, the professional staff, the administration, or no one. If the patient comes out on the short end, it's time to consider change! Some of these areas are included in the following list:

- a. Patient appointment systems.
- b. Patient record system (location and availability).
- c. Clinic referral system.
- d. Waiting periods.
- e. Hours of operation.

#### **4-4. Importance of good interpersonal relations among the staff**

The patient's world is the medical treatment facility. His or her attitudes and behavior to a large extent are the result of the attitudes he or she senses in the hospital setup. Poor organization often leads to inefficiency, to misunderstanding, or to actual conflict among the personnel. Any conflict, however slight, in the staff is sensed by the patient and makes him or her feel insecure. Insecurity causes him or her to increase complaints, and it slows down recovery. The aim of the health care teams is to restore. To the technical skill must be added the warmth of human feeling and compassion. It is expedient to examine not only the behavior of the patient but also the atmosphere in which he or she is being treated.

a. *Factors influencing interpersonal relations among the staff.* In order to maintain an atmosphere that is conducive to positive patient attitudes, all staff members should keep in mind that relations among themselves are significantly influenced by factors such as the formal organization of the health care facility, and by the informal organization (not officially sanctioned) features of an organization. The formal organization chart of a military hospital establishes a highly stratified and rigid social structure with recognized divisions of labor, communication patterns, and authority hierarchy. Maintaining this social structure are officially established regulations, rules, and policies designed to enhance the efficiency of the complex system of patient care. Changing the organization of health care is not an easy task. It requires support from the very top of the hospital management and professional structure. Change frequently fails to come about, however, because people who work at lower levels in an organization fail to take the initiative and inform management of the problems in their areas. These problems can develop at any level of an organization and result in an inability to solve human relations problems.

- (1) Symptoms of organizational dysfunction frequently observed are—
  - (a) Little personal investment by the staff in organizations' objectives and goals.
  - (b) Policies, directives, and orders not being carried out as intended.
  - (c) Competition between staff rather than cooperation or collaboration.
  - (d) Failure of staff to report problems although they see things going wrong.
  - (e) Staff blames others for problems instead of taking responsibility and seeking solutions.
  - (f) Staff taking refuge in procedures and policies (*we have always done it this way*) instead of searching for better alternatives.
- (2) Some selected causes of organizational dysfunction are as follows:
  - (a) Tight control over decision making with little staff participation allowed.
  - (b) Staff judgment not being respected by administrative and supervisory personnel.
  - (c) Rejection of the experience of others,
  - (d) Lack of positive feedback on good performance.
  - (e) Lack of corrective feedback on poor performance.
  - (f) Tradition encouraged; innovation discouraged for fear of making a mistake.
  - (g) Inadequate mechanisms for communication up, down, and sideways in the organization.
  - (h) Insufficient direct observation by supervisors.
- (3) Within the formal social system, individuals, professional and nonprofessional groups, and departments compete for status, recognition, and privileges while still focusing on the mission of the patient care. The formal structure is

often supported or subverted by the informal social relationships that emerge among personnel. These traditional groupings, norms, and goals are often informally developed in order to get the job done faster. From these nonofficial groupings emerge attitudes toward the job, toward staff members, and toward patients that can be either detrimental to the efficiency of medical teamwork, or can help create a positive atmosphere for achieving the formal goals of the hospital.

*b. Personal factors to consider as a member of a health care team.*

(1) Becoming better acquainted with yourself will help you understand why you feel as you do toward people in certain situations. Since no one remains the same day after day, striving to understand yourself is a continuous process. Acquiring some awareness of yourself will give you better self-control and help you to develop desirable attitudes that will influence your approach to staff members. Good informal relations can be promoted if you take time to consider some of your own attitudes by asking yourself:

- (a) What are my goals (for the immediate situation and the future)?
  - (b) How am I going about trying to reach these goals?
  - (c) How have my family, my social group, and my training influenced my opinions and what I think?
  - (d) Do I really believe these things, or do I try to make myself and others think I believe them because I am expected to believe them?
  - (e) Do I prejudge people, making up my mind in advance whether I like them or not because they are of a certain race, religion, occupation, or social group?
  - (f) Am I interested in the work I am doing and does it satisfy me?
  - (g) Do I resent some things about my supervisor?
  - (h) How do I feel toward those who work under me?
  - (i) How do I get along with those who work on the same level with me?
  - (j) Am I glad or resentful when one of my peers is praised or receives a promotion?
  - (k) How do I react when I make a mistake? Do I admit it or make excuses to try to cover it up? Do I brood over it and feel inferior for awhile?
  - (l) Do I have enough sense of humor to laugh at myself?
  - (m) Do I accept others as they are, realizing that each individual is different?
  - (n) How do I react to criticism? To praise?
  - (o) How do I seem to affect other people, especially those whom I meet often or work with?
- (2) Understanding yourself is a forward step toward good interpersonal relations.

#### **4-5. Attitude toward the patient on the ward**

On the ward the patient comes in contact with people from many groups besides the medical and nursing care team—the food service division, the custodial service, the chaplain, the American Red Cross, and others. All are there for one aim: to help the patient recover as completely and as quickly as possible. It is easy to forget this purpose and become lost in your own little world. It is not difficult to slip into the attitude that you are doing the patient a favor and that he or she should be grateful for your services. Actually you exist only because the patient is there; your services to him or her must be given politely and willingly. Even though he or she appears unreasonable in his or her demands, you must exercise self-control in order not to irritate him or her further or antagonize him or her toward the hospital. Keep in mind that noise, being awakened early, and being served cold food can set off a chain of undesirable reactions on the part of the patient. Remember that our society places high value on cleanliness as it is related to health. The slovenly appearance of dirty, unkept uniforms may be detrimental to the patient's respect for the health care team. Hospital personnel tend to give more attention and sympathy to the critically ill, the helpless and those obviously in pain. They tend to forget those without obvious disability, sometimes even having the attitude that these patients are pretending to be incapacitated in order to shirk responsibilities. Decisions on such questions lie only within the scope of the psychiatrist and physician. As long as a person is in a patient status, it is his or her right to receive competent care, cheerfully given by all personnel with whom he or she comes in contact.

#### **4-6. Helping the patient cope with stress**

*a. Relieving frustration and anxiety.* To a limited degree, frustration and anxiety in patients can be prevented by satisfying their needs. Physical needs such as hunger, fatigue, a comfortable environment, and freedom from pain can usually be satisfied with the help of modern equipment and drugs, combined with technical, nursing, and medical skills. Unfortunately, the emotional needs of the patient are more complicated, often difficult or impossible to identify. Continuous and conscious attention must be directed toward satisfying emotional needs if the patient is to recover as speedily as possible. *For example, many a restless, complaining patient has been quieted simply by having a nurse or corpsman sit by his or her bed for awhile and talk to him or her.* What is talked about is not too important; *the patient needs and receives attention.* In nearly all cases, if the disturbing element (the case of the blocked goal) can be recognized early enough, problems can be satisfactorily solved and a normal adjustment made. Anxiety, if recognized in its early stages, can often be relieved before it becomes acute. Frequently, a simple, straightforward explanation of what to expect will alleviate many anxious feelings.

*b. Preventing overdependence.* In a hospital situation a patient must usually become dependent on the nursing staff and others for services he or she has performed him- or herself when he or she was well. This is a satisfactory arrangement as long as he or she actually needs to have these things done for him or her. *To prevent overdependence, all personnel who deal with the patient should encourage him or her to do everything for him- or herself that the physician feels it is wise for him or her to do.* Reacquiring independence must go hand-in-hand with recovery, and all services can assist in the process.

*c. Guiding aggressiveness.* Inactivity coupled with tension very frequently results in aggressive behavior. Keep this in mind and *provide some type of activity, either physical or mental rather than foster the opinion that the patient is impossibly unruly.* Even when he or she seems to deliberately try to be difficult or in some cases quarrelsome with you and others, remember that there is a cause for his or her behavior. If you can discover the cause, or if you can provide alternative outlets for his or her aggressive tendency, you may make a valuable change in his or her behavior.

*d. Minimizing withdrawal.* The patient who withdraws is more difficult to cope with than the aggressive person. He or she takes no part in the everyday banter of other patients. *He or she refuses to discuss him- or herself or his or her troubles with you or others.* You cannot rush him or her or force him or her; he or she is easily antagonized and retreats into his or her own private world even further. *You must employ all your imagination to interest him or her in something and try to gain his or her confidence by demonstrating your kindly interest in him or her each day.* Think of ways to rebuild his or her self-confidence. Ask him or her to perform a small task that you know he or she is capable of achieving, and then compliment him or her for the accomplishment. Try to interest him or her in other patients; ask him or her to help one of them. It should not be too long before you begin to see the results of your efforts and you will have the deep satisfaction of having done something very worthwhile for a fellow human being. Above all, *be patient.*

*e. Decreasing aggression.* If you observe that a patient is overly dependent or is acting in a childish, immature manner, the best thing you can do for him or her is make him or her responsible for something that he or she can accomplish. *Asking him or her to be responsible for something such as taking part in his or her own treatment or care will make him or her feel important and needed.* You can gradually increase his or her responsibility in proportion to his or her development. Overlook his or her occasional failures; appear to regret them but do not reprimand him or her. Say that you know that he or she will be more successful next time. The confidence you have in him or her must be genuine; he or she will be quick to sense any insincerity on your part.

*f. Solving conflicts.* Many patients are disturbed because they have problems which they are having trouble working out. *If a patient has a problem and wants to tell you about it, hear him or her out if you can possibly spare the time.* If you put him or her off, he or she may not want to talk about it when you return. Listen attentively to him or her and try to understand his or her point of view on the matter. A solution may occur to him or her just by putting his or her thoughts in order concerning the matter. If it does not and he or she seeks your help, encourage him or her to use the logical approach to solving his or her problem (para 2–10a). Your interest and your help will increase his or her confidence in him- or herself, thereby preparing him or her to solve more successfully other problems which may confront him or her in the future.

#### **4–7. Guidelines for constructive interpersonal relationships with patients**

Since you work closely with the patient, you are in a desirable position to make early responses to his or her needs and to establish relations that will contribute to his or her recovery. To carry out your role effectively, keep in mind the following guidelines:

*a. Like you, the patient is a human being with complex needs and motivations.* Try to imagine yourself in his or her position—in an unfamiliar environment trying to adjust to the stress of illness and injury. How do you think you would feel? How would you like to be treated by those around you? Let your answer to yourself to be a general guide for approaching the patient.

*b. In your relations with the patient, use a genuine, friendly approach.* Based on a feeling of concern for him or her as a fellow human being. You will draw a genuine response for he or she will sense your sincerity.

*c. Accept him or her as a unique and worthwhile individual.* Show by your attitudes, words, and actions that you are willing to understand his or her feelings and to accept the fact that there is a reason for them that is important to him or her.

*d. Well-informed patients are less apprehensive and more cooperative.* You can lessen their anxiety by providing explanations in the patient's own terms and as often as it seems necessary. Let him or her know that he or she can feel free to ask questions.

*e. A patient often feels hopeless, insecure.* By showing that you are interested enough to hear what he or she has to say, you can help him or her develop feelings of hopefulness and assurance about him- or herself and those who attend him or her.

*f. The role of dependency should last only as long as the patient's needs require it.* All personnel who deal with the patient should encourage him or her to do everything for him- or herself that the physician feels is wise for him or her to do.

*g. Become better acquainted with yourself.* Acquiring some awareness and understanding of yourself will give you

better self-control and help you to develop desirable attitudes for maintaining good interpersonal relations with the medical treatment team and with the patient.

*h. Learn to recognize and accept different ways of living, values, beliefs, and the limitations and assets of others.* Our society has a much wider variety of these factors than is often recognized. Develop an awareness of the other person's point of view, and of the differences and similarities between his or hers and yours.

*i. Since the patient's attitudes and behavior are influenced by the attitudes of those around him or her, positive interpersonal relations among members of the medical staff must be considered as part of the process of total patient care.*

*j. Because people tend to accept the ways of the group as their own, it is expedient to develop and maintain a positive social atmosphere among members of a ward so that new patients will adopt positive attitudes toward the hospital and toward recovery.*

*k. The acts of reassurance and persuasion, when skillfully employed, are highly recommended for implementing interpersonal relations with patients.*

#### **4-8. Positive value of good interpersonal relations**

Seeking to understand the behavior of patients and thereby helping them to overcome anxiety, frustration, and conflict must never be considered *pampering the patient*. Good interpersonal relations with patients have a positive value in speeding and making more complete the patient's recovery, an accomplishment which is beneficial both to them and to the hospital. In addition to these rewards, harmonious, efficient organization enhances the job satisfaction of the health care team. *Through developing genuine interpersonal relations you will achieve the satisfaction of having promoted human dignity among your fellow human beings.*

## **Chapter 5 RECOMMENDATIONS**

### **5-1. Diagnosing human relations problems in your facility**

Solutions to human relations problems do not come easily. The problems themselves arise from many sources. The human behavior involved frequently stems from people's habitual way of relating to others or in many cases as a response to unavoidable pressure. One thing is definite: problems cannot be solved if we have not identified them. This section of the pamphlet introduces supervisors to some checklists and a questionnaire which will help identify problem areas. Once you have identified the problems, you can then establish objectives toward which you can move. Some of your objectives will be in the administrative area and will require initiating action to make a change (i.e., a work order requesting a modification in the physical environment). Other objectives will be related to staff behavior and will necessitate systematic supervision and perhaps a training program built around the need for information or discussion pertaining to a specific problem.

*a. Check out yourself.* What are your objectives for improving human relations in your area? Do you have any? Supervisors and administrators set the tone for an organization, so begin with yourself. Part I, appendix C, provides you with a few questions that will help clarify your goals. Take a few minutes out for self-study. Answer the questions. The answers will help you identify steps you need to take. If you do not have human relations goals, the chances are that your staff does not either. If this is true, many of the problems discussed earlier are probably interfering with effective patient care in your area.

*b. Check out your staff.*

(1) *Observe.* Knowing your staff and how they relate to patients is an important part of diagnosing human relations problems in your staff. This means that you need to observe and ask questions. Attitude is important here. If you see this task as *checking up on people* they will become defensive and the problems will get worse. If your motives are to be helpful, the manner in which you ask questions and observe behavior should reflect an attitude of *I want to understand and be helpful* rather than *I want to see if you're making mistakes*. In observing how your staff interacts with patients, you should not overlook the *little things*. Small bits of behavior make up common courtesy. The importance of a smile, pleasant tone of voice, and eye contact cannot be overemphasized in creating a positive human relations environment. It does little good to say to a patient, *"I am concerned about you,"* if we say it in a tone of voice that means the opposite, or if we say it while our attention is on something else we are doing. The checklist in part II, appendix C, is designed to help you observe the little behaviors that help build good human relationships. It also asks some general questions about the way different people are treated. *Rank has its privilege* is a common saying; however, a sick private feels just as bad as a sick colonel. Even the appearance of discriminating treatment needs to be based on how they see it. The result of this perception is patient dissatisfaction and in no way contributes to the goal of good human relations in patient care.

(2) *Interview.* In addition to observing your staff, make an effort to talk with them. Find out how they view their jobs, the clinic, and the patients. To begin with, the following list of questions will give you plenty of information with which to work, but you will probably be able to develop more:

- (a) How are things going around here?
  - (b) What changes would you like to see?
  - (c) How do you think this organization could be more effective? What do you feel it does best? Does poorly?
  - (d) Are you kept informed of what goes on?
  - (e) When there are problems here, what can you do about them?
  - (f) When there are problems between this area and other parts of the hospital, what can you do about them?
  - (g) Can you give some examples of problems that you have on the job?
  - (h) How do you think the patients view us?
  - (i) Do you think that we can improve the way we treat people here? If so, how?
- c. *Check out your patients.*

(1) *Observe.* In observing your staff, it was suggested that you look at *small behaviors*. The same is true when observing patients. Many times a facial expression or a momentary hesitation can tell you more than a lengthy interview. You need to ask yourself, "*Is this clinic an easy place to visit or is it frustrating and confusing?*" Part III, appendix C, gives you some questions that you should be able to answer by observing patients as they come through your clinic. You will need to take some time to make your observations. Pick a few patients at random over a 2-week period of time, watch them come, wait, and leave. Keep some notes on your observations. You can use these data later. You do not have to be obvious in your observations nor do you have to sneak around like a *private eye*. Position yourself where you can observe the waiting area, or for that matter, take a seat in the waiting area. You will also get a feel for the physical environment as well. Make your periods of observation long enough so that you get a feel for what it is like for the patient.

(2) *Interview.* You do not need to conduct a formal interview to find out how patients feel about their experience in receiving health care. Casual conversation will provide you with a great deal of information. Express interest in the patient's experience and avoid becoming defensive if you get some negative reactions. A side effect of your expressed interest will be a happier patient. Most of us feel better when another individual expresses an interest in what we think. A cautionary note should be given: *do not let praise go to your head*. Some studies of patient's opinions of health care have found that many patients are afraid of expressing negative feelings about health care lest they receive worse care as a result. Unfortunately in some situations that concern is well-founded.

(3) *Survey.* Another way to get feedback about your patients' experience in your facility is to have them fill out a brief questionnaire. An example of a patient feedback questionnaire for use in a clinic can be found in appendix D. You may want to use this one as it is, or modify it to fit your own situation better or prepare a new one for an inpatient survey. One rule of thumb that is important: *keep it brief and easy to answer*. Questionnaires are not a substitute for talking with patients directly, but they have some advantages in diagnosing problems in patient care, namely—

- (a) They allow you to sample a large number of people; thus get a wider range of experience and opinion.
- (b) The patient can respond anonymously, if he or she wishes.
- (c) They take little of your time to administer.
- (d) The results can be easily tabulated and used to give feedback to the staff.
- (e) They can be used over long periods of time to let you know if patient care is improving, staying the same, or getting worse. As implied, there are a number of ways to use a patient feedback questionnaire. You can have all of your patients fill it out or give it to a sample of your patients. If you decide to sample your patient population, do it in a systematic way. One way to obtain a fairly random sample is to pick every 5th or every 10th patient. Administer the questionnaire every day over a period of time, no less than 1 week. This way you should cover most of the types of patients who come to your clinic. A questionnaire given to inpatients may be harder to evaluate. Timing is critical and must be a consideration. Upon admission, during hospitalization, or at discharge a patient's attitudes and opinions may vary widely. Anonymity is another factor that may affect responses. Providing drop boxes or envelopes for the return of questionnaires should be considered. Questionnaires do little good if you do not tabulate and use the results. While reading through questionnaires can prove interesting, unless you add up their responses over a period of time, much of the use is lost. Even the most objective reader tends to remember the dramatic answer or the answer he or she wants to hear. This will not result in an accurate diagnosis.

d. *Formulating your diagnosis.* If you go through the process of utilizing the suggested feedback systems, you will have a great deal of information. You then need to organize these data in some way. One possibility is to place it in the framework of patient problems, staff problems, environmental problems, and health system problems. The next step is to define what your behavioral objectives are for change in each of these areas. It is around these objectives that you can act, as an administrator, in supervision, in staff training, and in patient education. You cannot do it alone, but now you have information which your staff can use to improve patient care. One of the major problems that you will face is getting your staff to join you in an effort to improve the human relations climate in your facility. One first step might be the use of the supervisory relationship with your personnel to obtain their input and suggestions. In addition, if you plan your staff training in a way that allows for maximum participation by the staff, your chances of success are going to be far greater than if it is a one-sided matter.

## 5-2. Influencing staff behavior

*a. Supervision.* Careful supervision of personnel provides the most effective means for influencing staff behavior. Supervision should involve the clear communication of specific expectations, and the provision of such assistance as may be needed to assure that those expectations are consistently met. Certain supervisory principles can be recommended:

(1) *Emphasis.* It is well known in the Army that expectations are most likely to be met when they receive command emphasis. Supervisors must continuously emphasize that staff contacts with patients and patient-families are to be characterized by courtesy, concern, and compassion. As much as possible, this generalized expectation should be translated into emphasis upon specific behavioral expectations such as in the manner of greeting patients, in the manner of giving directions, in the manner of dealing with inquiries, and the like.

(2) *Orientation of new personnel.* The supervisor's orientation interview with the new staff member provides a splendid opportunity to emphasize the importance of courtesy and concern, and to outline some of the specific expectations for dealing with patients.

(3) *Positive reinforcement.* To get consistently positive results, desirable behavior should be rewarded. Praise is an effective and inexpensive means to shape behavior. Be generous with recognition, to include public recognition. Share with your staff letters of appreciation written by patients in response to concerned and courteous care.

(4) *Correction of inappropriate behavior.* When necessary, correct inappropriate behavior toward patients and patient-families. Such corrections must be prompt, firm, and fair. They should leave your expectations completely unambiguous. When possible, explore with the staff member the specific troublesome interaction with the patient, and remind him or her how it should have been dealt with.

(5) *Providing a model.* Staff members look to their supervisors for leadership and example. Your own contacts with patients and the manner in which you discuss patients will be observed by your staff. In this manner, as in all others the supervisor must be a good role model. Your actions will speak louder than your words.

*b. Training.* If a training program is going to result in meaningful behavior change, it must be tailored to the behaviors that need changing. It is far better to establish behavioral objectives which relate to your situation than to rely on a *canned approach* designed to meet the general needs of all health care facilities. Studies of organizational behavior support the observation that people are much more willing to change if they feel that they have a voice in the process. It is also one that allows free discussion of these problems among your staff and draws on their experience and knowledge in finding solutions. A lecture or a film presentation alone seldom involves people enough to produce any real change. These approaches ignore many of the innovative ideas of which people are capable, if given the chance to participate. A seminar or group discussion approach, if well run, can go much further toward developing an effective approach to improving human relations.

(1) *Establish objectives.* Objectives have been emphasized throughout this pamphlet. By the time you finish diagnosing the human relations climate in your area, you should have a list of objectives that will provide topics for staff training for an extended period of time. If, however, you are the only one who has these objectives, the prospect of changing human behavior in your organization is not very good. Thus, the first step in a staff training program should be to have the *staff develop their own objectives* for improving human relations. After your staff has done this, you can share your objectives with them. Frequently, this approach demonstrates that people who work at different levels of an organization share the same goals. It also allows you to check out how realistically you view your organization's capacity for change. The staff should be encouraged to discuss your objectives and integrate them with their own. Make sure that a record of staff objectives is made for use as you develop your training program further.

(2) *Making objectives specific.* *To improve human relations* is too general. *To develop courteous telephone answering skills*, is much more specific and gives you a more easily defined set of behaviors around which to build a training session. A well defined set of objectives lends itself to questions which can serve as the basis for a staff seminar discussion. You should develop the discussion questions in advance of your training sessions and be prepared to present supporting material. Your diagnostic work should have prepared you with sufficient material. If you need more, use the reference materials cited in appendix A.

(3) *Design a training program.*

(a) To help your staff develop its objectives for improving human relations, your first training session should be conducted as a group conference study. The following is a good procedure for this type of training:

1. *Divide your staff into two or more groups.* Each group is asked to develop three lists.

- What is the way we see ourselves as a staff?
- What is the way we see the patients?
- What is the way we think the patients see us?

2. *Bring the groups back together again.* Have a spokesman for each group read the three lists. No discussion is allowed at this time.

3. *Have the groups go back and remake their lists*, taking into account what they have heard from the other groups.

4. *Bring the groups together to discuss their final lists.* Suggest that each individual begin to think about specific things that need changing.

5. *Have each group develop a list of priorities* for change, phrasing them as objectives. (You can repeat the process of 2, 3, and 4, above.)

6. *Share the objectives.* After you have a list of staff objectives ordered in terms of priority, *share the objectives you have with the staff.*

7. *Allow time for discussion of your objectives* among the total group and then have smaller groups *integrate your objectives with theirs.*

8. *Conclude the session by listing all of the objectives discussed.* Make this list available for staff study and thought. Leave room for adding to the list as your training program develops.

(b) Plan your future sessions around specific objectives. Begin with those which you and your staff feel have the highest priority and those that will produce immediate change.

1. *Prepare discussion questions* for each objective and if possible present them in advance to your staff.

2. *Sessions can be augmented by films*, such as those listed in appendix B *or by selected guest speakers* who have information pertaining to the subject.

3. *You should always allow time for the participants* in the training *to discuss the material.* Keep the emphasis on direct application to your situation.

4. *If you survey your patient population*, the results of the *survey can serve as the topic for an entire training session.* Use this information as a tool to help your staff develop a diagnosis of themselves.

(c) Additional guidance assistance in both developing and implementing a successful human relations training program are available within your Army medical treatment facility behavioral science resources. The department of psychiatry, psychology service, or social work service have staffs of professionals who are trained in understanding the dynamics of human behavior. These people may be utilized to help you design or conduct your training program.

(d) The advantages of this approach to training are numerous. Not only are you making needed information available to your staff, but you are also involving them in the training process. Making people aware of problems often creates an immediate change in behavior simply because people begin thinking about what they do. Another desirable side effect of this approach is improved communication among staff members. Problems are out in the open where they can be dealt with directly rather than covertly. In addition, you are in a better position to deal with your staff, as well as with other elements of the hospital, when you know what the problems are. The end product will be a better human relations climate and reduced patient dissatisfaction.

## Appendix A REFERENCES

### A-1. Field manual

FM 8-24 (Community Health Nursing in the Army).

### A-2. Technical manual

TM 8-230 (Army Medical Department Handbook of Basic Nursing).

### A-3. Miscellaneous publications

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## **Appendix B**

### **TRAINING AIDS**

#### **B-1. Miscellaneous Film (MF)**

##### **8-4948**

Make Life a Little Easier (Color, 23 minutes). Human relation techniques are shown which can result in improved patient care and reduced human relations problems.

##### **8-5539**

You in OPD—Outpatient Department (Color, 23 minutes). Human relation techniques are shown that can be applied to outpatient facilities to cope with everyday human relations problems.

##### **8-5630**

Mrs. Reynolds Needs a Nurse (Black-White, 38 minutes). Dramatizes the value of personalized nursing, based on a case study of a patient problem.

#### **B-2. Title not used.**

Paragraph not used.

## Appendix C

### SUPERVISOR'S DIAGNOSTIC CHECKLIST

#### C-1. Part I. Questions to check yourself out.

1. What are the *human relations problems* that exist in my clinic?
2. Am I aware of the *attitudes and feelings of patients* toward their medical care? If so, list the attitudes and feelings.
3. What are my *objectives* for improving human relations in areas that pertain to the *patient's response to medical care*?
4. What are my *objectives* for improving human relations that pertain to the *staff*?
5. What are my *objectives* for improving human relations that pertain to the *medical environment*?
6. What are my *objectives* for improving human relations that pertain to the *health care delivery system*?
7. How will the above *objectives* benefit patients and staff in the *effective receiving and delivering of health care*?
8. Do I encourage the staff to *discuss patient-staff problems* with me?
9. Does my staff *know* what is expected of them?
10. What are the ways *I communicate* to my staff the *objectives* I want them to perform?

#### C-2. Part II. Questions to check your staff out.

1. Do they *look at patients* when they are talking with them?
2. Do they *smile*?
3. Do their *posture and gestures* also indicate an interest in what the patient is saying?
4. Do they *explain things* to the patient and then check to be sure the patient *really* understands?
5. Do they *perform other activities* (answer telephones, file records, type, etc.) while interacting with patients?
6. Are *questions from patients* answered in a courteous and pleasant voice?
7. Do they *speak with patients* in such a way that they cannot be easily overheard by other people in the area?
8. Do *patients of different ranks* receive different or preferential treatment?
9. Do *patients who appear well dressed and groomed* receive better treatment?
10. Do *patients of different races* receive different treatment?
11. Do *patients who are less articulate or speak a foreign language* receive different treatment?
12. Does the staff *explain to patients* the reasons for an extended *waiting time* or why specific patients are *seen out of turn*?
13. Does the staff *pay prompt attention* to patients who are in obvious *distress and pain*?

#### C-3. Part III. Questions to check the patients out.

1. Do they know *where to go* or do they frequently have to request directional information?
2. Do they know *outpatient procedures*, such as—
  - (a) How to obtain an *appointment* or change an appointment time, if needed?
  - (b) Where to obtain their *medical records*, if needed?
  - (c) How to see the *same physician again*, if possible?
  - (d) *Hours of clinic operation* to include the laboratory, X-ray, immunizations, and the pharmacy?
3. Are their *personal conversations* with the physician *overheard* by others? Is there a lack of *privacy*?
4. Do they see the *staff drinking coffee or eating food* while they are waiting to be seen by a physician?
5. Do they *know where to go after* they leave the clinic and when to return if necessary?
6. Do they appear *comfortable* in the waiting room?

## Appendix D

### PATIENT QUESTIONNAIRE

#### D-1. Patient Questionnaire

Patient Questionnaire.

## PATIENT QUESTIONNAIRE

The following questionnaire is presented as a suggested format to be considered when surveying outpatients' views of medical care provided. Local differences will usually determine what items will be modified, added, or deleted. Another questionnaire could be prepared for inpatients which would include questions about admission procedures and food service, as well as many of the following questions modified as necessary.

We are interested in your opinion as a means of evaluating our work. Patients have contributed many worthwhile suggestions which have helped clinics such as ours to improve service to our patients.

Please complete this questionnaire by placing an "X" in the column for the response that best represents your experience in the clinic today.

|  | Yes   | No    | Does not<br>apply |
|--|-------|-------|-------------------|
| 1. Was your reception in the clinic handled in a courteous and understanding manner? .....   | _____ | _____ | _____             |
| 2. Did you have an appointment today? .....  | _____ | _____ | _____             |
| 3. Did you understand what you were supposed to do before your appointment? .....  | _____ | _____ | _____             |
| (Example: Pick up your medical records, lab work, X-rays, etc.) .....  | _____ | _____ | _____             |
| 4. Were the following clinic personnel responsive to your needs?   |       |       |                   |
| a. Clerical support personnel (receptionist, clerical, appointment)...   | _____ | _____ | _____             |
| b. Nurses .....  | _____ | _____ | _____             |
| c. Enlisted corpsmen .....   | _____ | _____ | _____             |
| d. Civilian medical technicians .....  | _____ | _____ | _____             |
| e. Physicians .....  | _____ | _____ | _____             |
| f. Laboratory technicians .....  | _____ | _____ | _____             |
| g. X-ray technicians .....   | _____ | _____ | _____             |
| h. Red Cross volunteers .....  | _____ | _____ | _____             |
| i. Other (Specify) .....   | _____ | _____ | _____             |
| 5. Did the clinic personnel explain what they were doing for you (procedures, findings, future treatment)? .....                     | _____ | _____ | _____             |
| 6. Did you receive clear and accurate directions and instructions on using prescribed medications? .....                             | _____ | _____ | _____             |
| 7. Do you feel that you received the same attention and care that other patients in the clinic received? If not, please explain why. |       |       |                   |
|  |       |       |                   |
| 8. Do you feel that you were examined in privacy? .....  | _____ | _____ | _____             |
| 9. Did you receive any pamphlets explaining clinic hours, appointment procedures, etc.? .....  | _____ | _____ | _____             |
| 10. How long did you wait in the clinic before being seen? Please circle one of the below.   |       |       |                   |
| a. 1-15 minutes      c. 31-45 minutes      e. 1-2 hours  |       |       |                   |
| b. 16-30 minutes      d. 46-60 minutes      f. Over 2 hours  |       |       |                   |
| 11. How would you rate the care you received today in comparison to your past experience in other military clinics?                  |       |       |                   |
| a. Excellent      b. Good      c. Fair      d. Poor  |       |       |                   |

Figure D-1. Patient Questionnaire

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If you wish to add anything to the answers you've given above, or make additional comments, please use the space below:

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**OPTIONAL PATIENT INFORMATION**

**NAME:** \_\_\_\_\_

**RANK OR SPONSOR'S RANK:** \_\_\_\_\_

**MALE OR FEMALE:** \_\_\_\_\_

**ACTIVE DUTY, DEPENDENT, RETIRED OR OTHER:** \_\_\_\_\_

**AGE (circle one):**    1-10    11-20    21-30    31-40    41-50    **Over 50**

Figure D-1. Patient Questionnaire—Continued

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**D-2. Title not used.**

Paragraph not used.

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